

178064

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified to the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 may be retained within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical certificate is required.

DMMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	5	1	7	2	4	2
												REG. NO. 17242						
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR P.M.						
Robert O. Baldwin									June 10, 1985			8:45						
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.			IF UNDER 1 YEAR MONTHS DAYS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana			7b. CITIZEN OF WHAT COUNTRY? USA.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Charles			10. KIND OF BUSINESS OR INDUSTRY Murphy+Ames						
10. CITY OR TOWN OF DEATH LaPlata			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor			12b. MED.									
13a. STATE Virginia			13b. COUNTY Fairfax			13c. CITY OR TOWN Annandale			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 7355 Shenandoah Avenue						
14. FATHER'S NAME FIRST Franklin			MIDDLE B.			LAST Baldwin			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE S.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 225 05 1631			17. INFORMANT Priscilla E. Via: See # 13 above			18. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (ENTER ONLY ONE ENTRY PER LINE FOR PART 1a) AND PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			central vascular accident												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).			DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/10/85</u> 19 <u>85</u> to <u>6/10/85</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>6/10/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																		
22b. SIGNATURE Timothy Pace MD			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 16/11/85									
22e. ADDRESS Timothy Pace, MD			22f. ADDRESS Waldorf, Md. 20601															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 13 1985			23c. NAME OF CEMETERY OR CREMATORIAL Columbia Gardens			23d. LOCATION CITY OR TOWN Arlington, Virginia			COUNTY	STATE					
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes, Arlington, VA.			25a. ADDRESS Ives-Pearson Funeral Homes, Arlington, VA.			25b. DATE REC'D. BY REGISTRAR JUN 18 1985			25c. REGISTRAR'S SIGNATURE Julia Davidson Pendleton									

188004

178034

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 7 2 4 3

REG. NO.

1 -  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR				
Perry Francis Bastain Sr.						June 15, 1985				3:25AM				
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR				
Male			Caucasian	MONTH	DAY	YEAR	75	MONTHS	YEARS	IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				HOURS MIN.			
Maryland			U.S.A.			Charles								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
La Plata			Physicians Memorial Hospital						X-Ray Tech			NOS		
13a. STATE Maryland			13b. COUNTY Charles	13c. CITY OR TOWN Indian Head	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 81 Circle Ave.					
14. FATHER'S NAME FIRST Samuel			MIDDLE Basrain	LAST	15. MOTHER'S MAIDEN NAME Elizabeth				16. ADDRESS POBox 457					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Perry F. Bastain Jr				18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			212-14-3993											
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. DUE TO, OR AS A CONSEQUENCE OF (b)											
			19. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. DEGREE						22d. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Charles Prof. Bldg. Waldorf, Md 20601						22d. DATE SIGNED 6-15-85					
Daniel Howell, M.D.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE				
Burial			6/18/85	Trinity Mem Gardens			Waldorf, Charles, Md.							
24. FUNERAL DIRECTOR NAME Huntt Funeral Home			P. O. Box 156 ADDRESS Waldorf, Ms 20601						25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical



TO HOSPITAL OR ATTENDING PHYSICIAN: The  
attained by the hospital or attending Physician.

requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician and completed (lined in the funeral director, page 3) within 72 hours after death. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death or, to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH - 16 60M 7/84  
(VRA 15.4)

170109

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5	1	7	2	4	4
REG. NO.					
DATE OF DEATH	MONTH	DAY	YEAR	24 HOUR	
June 8	1985			12:15 AM	

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR					
MARY Howard BERGERON						June 8, 1985			12:15AM						
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR						
				Feb. 12, 1899			86		IF UNDER 24 HRS						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b>		MONTHS DAYS HOURS MIN.						
10 CITY OR TOWN OF DEATH <b>Indian Head</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>401 Bland Drive</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE <b>Md.</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Indian Head</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>401 Bland Drive 20640</b>	
14. FATHER'S NAME FIRST <b>Alexander</b>			MIDDLE <b>Howard</b>	LAST	15. MOTHER'S MAIDEN NAME FIRST <b>Lucy</b>			MIDDLE		LAST <b>Bowden</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>238-06-6012</b>		17. INFORMANT <b>Mamie B. Palmer, Same as line # 13</b>			ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of brain</i>															
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>5-23-81</i> to <i>5-23-81</i> , that (I) (we) last saw the deceased alive on <i>5-23-81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
27a. SIGNATURE <i>Ignacio T. Garcia, M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6-8-85</i>					
22a. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>LaPlata, Maryland 20646</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-11-85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Oakdale Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Spring Hope, Nash</b>		23e. COUNTY <b>North Carolina</b>						
24. FUNERAL DIRECTOR NAME <b>The Hunt Funeral Home, Waldorf, Md.</b>		25a. DATE REC'D BY FUNERAL DIRECTOR <b>JUN 12 1985</b>													

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189138

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 107-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, 2, AND 4 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 17245							
1- STATE REGISTRAR			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI. DEATH MATED <input checked="" type="checkbox"/> 6 27 85									2b. HOUR 100 M							
1. DECEASED NAME (TYPE OR PRINT)			FIRST JOSEPHINE MIDDLE APP			LAST BOWLING			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			2d. HOUR 110 M							
2. SEX Female			4 RACE White			5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS			7. IF UNDER 1 YR. IF UNDER 24 HRS. HOURS MIN							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO			7b. CITIZEN OF WHAT COUNTRY? U. S. of A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.										
10. CITY OR TOWN OF DEATH Charlotte Hall			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
13a. STATE Maryland			13b. COUNTY Charles			13c. CITY OR TOWN Charlotte Hall			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Route 1 Box 231 20622							
14. FATHER'S NAME FIRST Bernard			MIDDLE A			LAST App			15. MOTHER'S MAIDEN NAME Elizabeth			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 238-40-2479		17. INFORMANT Lloyd S. Bowling, Charlotte Hall, Md.		ADDRESS Rt. 1 Box 231	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ovarian Ca</u> , Aspiration DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) <u>Aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Minutes</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Year					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														DATE SIGNED 27 Jne 85					
ACTUAL SIGNATURE <u>H. M. Mahan Haft</u>			TITLE (SPECIFY) M.D. <u>Charles Co</u>			MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT) <u>H. M. Mahan Haft MD</u>			ADDRESS <u>58#1 Box 1020 LaPlata, MD 20648</u>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>			23b. DATE <u>06/28/85</u>			23c. NAME OF CEMETERY OR CREMATORIALY <u>Lee Crematory</u>			23d. LOCATION CITY OR TOWN <u>Clinton</u>			COUNTY <u>P.G.</u>		Md.					
24. FUNERAL DIRECTOR NAME <u>THE AREHART FUNERALS HOME, INC.</u>			ADDRESS <u>LaPlata, Md.</u>			25a. DATE REC'D. BY REGISTRAR <u>2000</u>			25b. REGISTRAR'S SIGNATURE <u>J. K. Kilday</u>										
(VR A15 ME (5))																			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH17246  
REG. NO.1- STATE  
REGISTRAR

193027

DIVISION OF VITAL RECORDS, 201 W. PENN ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH DAY YEAR	1b. HOUR	
Francis Eugene Brown						<input checked="" type="checkbox"/>	6/ 27/ 85		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	MONTH DAY YEAR	12. HOUR	
Male	Blk	Nov 9 '26	58	MONTHS	Days	6/ 27/ 85	PM	12:44	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		USA			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Charles County MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
La Plata			Physician's Memorial Hospital			Laborer			Construction
13a. STATE Md.			13b. COUNTY Prince Geo			13c. CITY OR TOWN Brentwood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS 4006 38th St., Apt #2									
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Richard Clarence Brown			Mabel Ford						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII			17. INFORMANT Francis Brown Jr. SAA			ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>			(b) DUE TO, OR AS A CONSEQUENCE OF			(c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Margarita A. Korell</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER									
DATE SIGNED <u>6/28/85</u>									
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS						111 Penn St.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5 July '85			23c. NAME OF CEMETERY OR CREMATORIUM Resurrection Cem.			23d. LOCATION Clinton
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUL 10 1985			25b. REGISTRAR'S SIGNATURE <u>M. Margarita Korell</u>
Mustell Adams			Aquasco, Maryland 20608						



190068

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 7 2 4 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	P	
Franklin Pershing Burge Sr.						June 28, 1985				9:23	M	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		July 14, 1917		67			MONTHS	YEARS	MONTHS	YEARS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		U.S.A.							Charles			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
La Plata		Physicians Memorial Hospital		Driver			Trucking					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE			
Maryland		Pr. George		Lanham		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5507 Belva Street/20801			
14 FATHER'S NAME		MIDDLE		LAST		15 MOTHER'S MAIDEN NAME			MIDDLE			
Webster				Burge		Ella			Funk			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO.		17 INFORMANT			18 ADDRESS			
No		- -		187-01-6227		Mary H. Burge			5507 Belva St., Lanham, Md. 20801			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>RENAL INSUFFICIENCY</u>												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
-		-				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (has/had) attended the deceased from saw the deceased alive on <u>6/28/85</u> 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.		6/17/85		19		to <u>6/28/85</u> 19_____,		19		19		
22b. SIGNATURE <u>Smishra</u>		DEGREE		22c. DATE SIGNED <u>6/28/85</u>								
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS										
Sanjeeb Mishra M.D.		Waldorf, Md 20601										
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL		23d LOCATION CITY OR TOWN		COUNTY				
Burial		7/2/85		Resurrection Gem.		Clinton		Pr. Geo., Md.				
24 FUNERAL DIRECTOR NAME		P.O. Box 156 ADDRESS		25a DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Huntt Funeral Home		Waldorf, Md. 20601		JUL 3 1985		Julie K. Kudzak, Randall						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon patient right and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Part II is marked as present, Part II (18) and Part II (21) is marked as present.



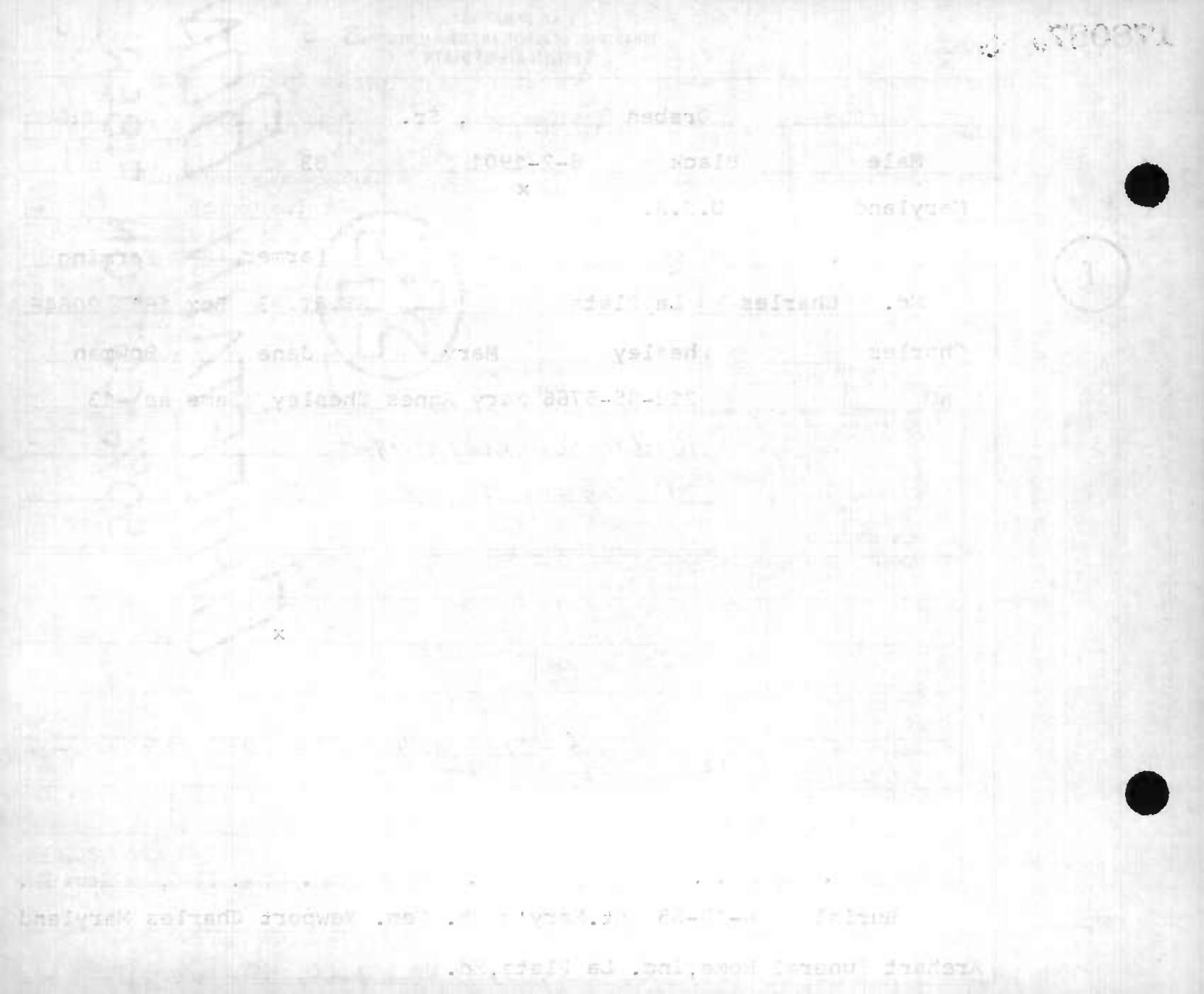
178087

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be paged at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	5	1	7	2	4	8								
												REG. NO.														
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR					
			Thomas			Orsben			Chesley			, Sr.			June 12, 1985						2:34 M					
3. SEX			4 RACE			5. DATE OF BIRTH			MONTH			YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
Male			Black			8-2-1901									83			MONTHS	YEARS	HOURS	MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/>			DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U.S.A.																		Charles County MD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																	
La Plata MD.			Physicians Memorial Hospital						Farmer						Farming											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE														
Md.			Charles			La Plata			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			ST. RT. #3 Box 161 20646														
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME			MIDDLE			LAST											
Charles						Chesley			Mary			Jane			Bowman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
NO			218-05-5766			Mary Agnes Chesley Same as #13																				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardio-Respiratory arrest																				
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF Pulmonary Embolism																				
			(c)			DUE TO, OR AS A CONSEQUENCE OF																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)																				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE												
22a. I certify that (I) (this hospital) attended the deceased from 6-7-1989 to 6-12-1989, that (I) (we) lost saw the deceased alive on 6-12-1989, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS																	
Girija S. Rath, M.D.			20601			St. Charles Prof. Bldg. 3200, Waldorf Md.																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			COUNTY		STATE												
Burial			6-17-85			St. Mary's Ch. Cem.			Newport			Charles		Maryland												
24. FUNERAL DIRECTOR NAME												25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Arehart Funeral Home, Inc. La Plata, Md.												JUN 18 1985			John A. Rendell											
DHMH - 16 60M 7/84 (VRA 15, 4)																										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed

by the attending physician and completed in full within 72 hours after death. Page 4 may

be detached for use as the burial transit permit. Then please remove carbon paper. Page 4

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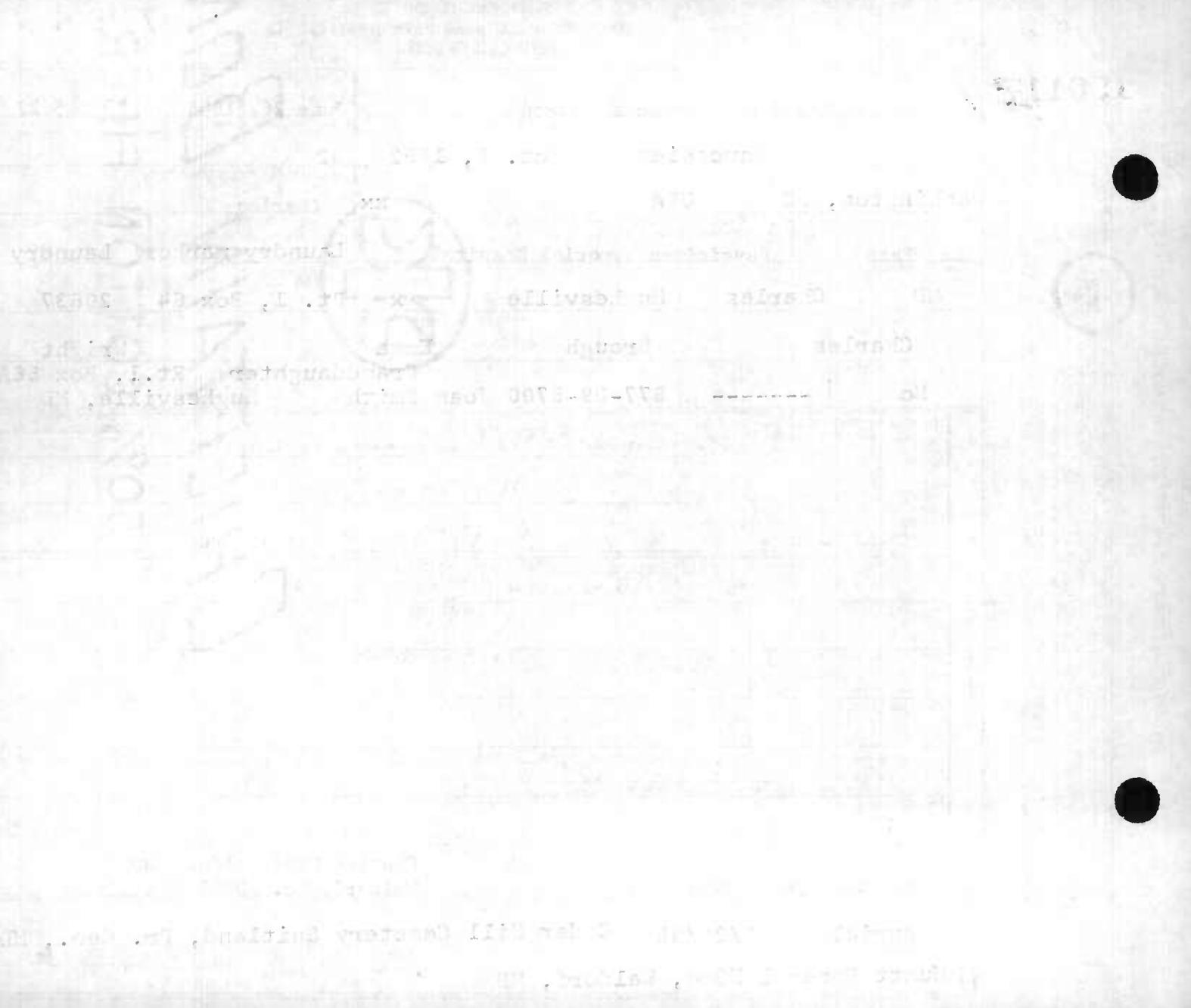
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 7 2 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Lillian Frances Coombs						June 26, 1985				5:27 A.M.		
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
Female			Caucasian	Oct. 5, 1892			92					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			
Washington, DC			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			Charles			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
La Plata			Physicians Memorial Hospital			Laundry marker			Laundry			
13a. STATE MD			13b. COUNTY Charles	13c. CITY OR TOWN Hughesville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. 1, Box 64 20637		
14. FATHER'S NAME FIRST Charles			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Emma			MIDDLE	LAST	Wright		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT Granddaughter			ADDRESS Rt. 1, Box 56A			
No			577-09-5700			Joan Smith			Hughesville, MD			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. DUE TO, OR AS A CONSEQUENCE OF (b)			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any.												
19. DUE TO, OR AS A CONSEQUENCE OF (c)			HYPTENSION									
20. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a			ASPIRATION PNEUMONIA									
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
						YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21i. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 6/25/1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Dr. Seetaramayya Nagula			22c. DEGREE MD			22d. ATTENDING PHYSICIAN DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 6/26/85			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Seetaramayya Nagula, M.D.			22g. ADDRESS Charles Prof. Bldg., Box 3 Waldorf, Md. 20601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 6/28/85			23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN Suitland, MD			
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, MD						24e. DATE REC'D. BY REGISTRAR JUL 01 1985			24f. REGISTRAR'S SIGNATURE Janet L. Rostek			
BP _____												
DHMH - 16 60M 7/84 (VRA 15, 4)												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from the back of Page 2 and file within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, attach a separate sheet of paper and describe in detail.

## MEDICAL CERTIFICATION

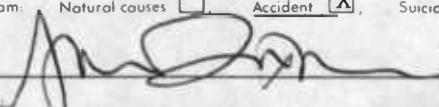
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	5	1	7	2	5	0				
										REG. NO.										
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR								
1271			GEORGE FRANCIS FENWICK						JUNE 30, 1985			9:45p.m.								
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.								
MALE			BLACK			FEB. 23, 1931			54 YRS											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
MARYLAND			U.S.A.						CHARLES											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
LA PLATA			PHYSICIANS MEMORIAL			FOREMAN			TRANSPORTATION											
13a. STATE MARYLAND										13b. COUNTY ST. MARY'S		13c. CITY OR TOWN CLEMENTS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. BOX 6, ROUTE 234 20624				
14. FATHER'S NAME FIRST JAMES MIDDLE THURMAN LAST FENWICK										15. MOTHER'S MAIDEN NAME LOUISE		MIDDLE		LAST		MILES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) YES 1951-1953			17. INFORMANT MRS. AGNES V. FENWICK, CLEMENTS, MARYLAND			ADDRESS P.O. BOX 6			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma lungs																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED AT WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE								
22a. I certify that (I) (this hospital) attended the deceased from 9-21-83, 1983, to 6-30-1985, that (I) (we) (did) (did not) last saw the deceased alive on 6-29-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE G. Shankar Rath, M.D.										DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-1-85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. SHANKAR RATH, M.D.										22e. ADDRESS CHARLES PROFESSIONAL CENTER, WALDORF, MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE BURIAL 7/5/85			23c. NAME OF CEMETERY OR CREMATORIAL QUEEN OF PEACE			23d. LOCATION CITY OR TOWN HELEN, ST. MARY'S, MARYLAND			23e. COUNTY STATE								
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, LEONARDTOWN, MARYLAND										25d. DATE REC'D. BY REGISTRAR JUL 05 1985			25e. REGISTRAR'S SIGNATURE							

BP



179029

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE FORMS 5, 12, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 4 AND 5 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201. PAGE 2 TO BURIAL, CREMATION, OR RECAVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 17251		
1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH 6 DAY 15 YEAR 1985 2b. HOUR 5:52P M											
1. DECEASED NAME (TYPE OR PRINT)			FIRST Arthur			MIDDLE Bushwood			LAST Fones, Sr.			2c. DATE ESTI- DEATH MATED <input type="checkbox"/> MONTH 6 DAY 15 YEAR 1985 2d. HOUR 5:52P M		
1. SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug. 22, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painting Contractor			12b. KIND OF BUSINESS OR INDUSTRY 20904		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11807 New Hampshire Avenue						
14. FATHER'S NAME Lewis		FIRST MIDDLE Howard		LAST Fones		15. MOTHER'S MAIDEN NAME Lucille		FIRST MIDDLE Rebecca		LAST Rowe				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. World War II		16c. ADDRESS 506 Mannakee Street		17. INFORMANT Arthur B. Fones, Jr. Rockville, MD. 20850								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8/20 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input type="checkbox"/> MONTH DAY YEAR 5:20 M. 6 15 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) Driver in auto/truck impact								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET RT. 301 & Patuxent Dr, LaPlata, Charles, MD.			CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St. Balto. MD.									DATE SIGNED 6/17/85		
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 6/19/1985			23c. NAME OF CEMETERY OR CREMATORY Gibeon Baptist Cemetery			23d. LOCATION CITY OR TOWN Village, Nathumberland			COUNTY STATE VA.		
24. FUNERAL DIRECTOR NAME James J. Jones			ADDRESS P.O. Box 276 Heathsville, VA. 22473			25a. DATE REC'D. BY REGISTRAR JULY 21 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					
(VR A15 ME (5))														

John D. M.

and Company

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury or other traumatic event, the medical certificate should be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	5	1	7	2	5	2		
												REG. NO.								
1. FOR STATE REGISTRAR			1a. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			Josephine C. Guarino									June 2, 1985						3:40 P M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. a. DATE OF DEATH			MONTH	DAY	YEAR	8. b. HOUR		
Female			Caucasian			Month Day Year			78			June 2, 1985			IF UNDER 1 YEAR	IF UNDER 24 HRS		3:40 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
New York			USA			December 28, 1906			Charles											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
La Plata			Physicians Memorial Hospital			Homemaker			Home											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
Maryland			Prince George's			Clinton						9417 Hale Drive (20735)								
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME														
Francisco Lazzaro						Florence Trapolino														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
No			N/A 579-28-4510			James V. Guarino, Sr. - Same As #13 A-E														
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												Supers.								
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular Accident.																				
DUE TO, OR AS A CONSEQUENCE OF (c) Debilitating disease.																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) this hospital attended the deceased from saw the deceased alive on 6/2 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death)												19 to 6/2 1985, that (I) (we) last								
22b. SIGNATURE			22c. DATE SIGNED			22d. DEGREE			22e. ADDRESS											
22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22h. ADDRESS			22i. LOCATION CITY OR TOWN COUNTY STATE											
G. WATSON			La Plata, Md. 20646																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial			June 5, 1985			Resurrection Cemetery			Clinton, Maryland											
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Lee Funeral Home, Inc.																				
Old Alexander Ferry Road, Clinton, Maryland						JUN 7 1985			John Davidson - Randall											



184137

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 7 2 5 3

1 - FOR  
STATE  
REGISTRAR

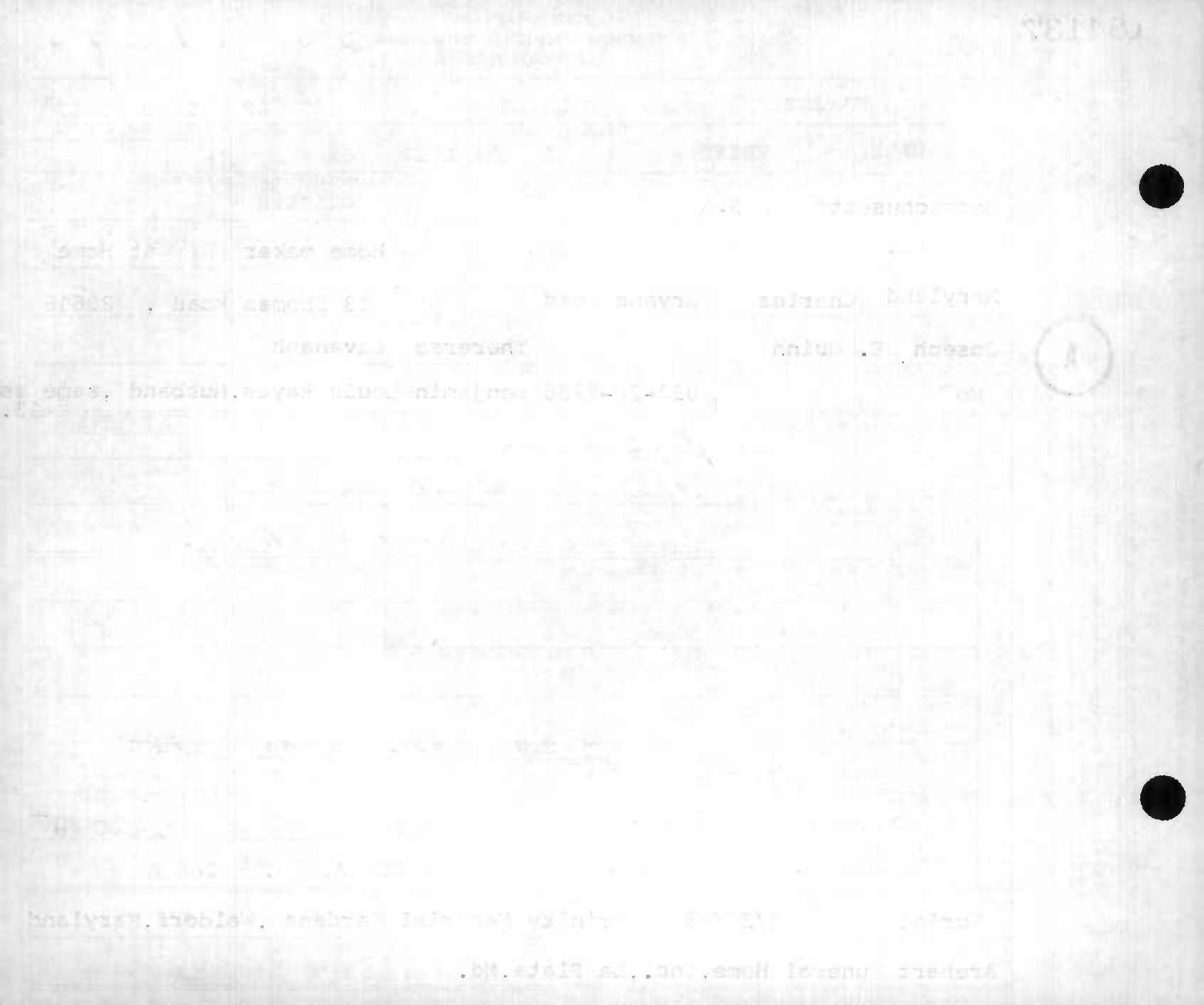
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
MARJORIE				E.		HAYES	6	22	1985	3:13 <sup>a</sup>			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		WHITE		MONTH	1	DAY	63	MONTHS	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES						
Massachusetts		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY			
LA PLATA, MD.		PHYSICIANS MEMORIAL HOSPITAL		Home maker						at Home			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland				Charles		Bryans Road		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	13 Thomas Road, 20616			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME							
Joseph E. Quinn						Thereresa Cavanagh							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No				032-20-2256		Benjamin Louis Hayes, Husband, same as							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepato - renal failure</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic cirrhosis of the liver</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
			P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-29</u> 19 <u>85</u> to <u>6-22</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>6-21</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>6-22-85</u>	
22b. SIGNATURE <u>Ignacio T. Garcia, M.D.</u>			DEGREE - PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/>		22d. ADDRESS LA PLATA, MD. 20646								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) IGNACIO T. GARCIA M.D.			22f. ADDRESS LA PLATA, MD. 20646										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/24/85		23c. NAME OF CEMETERY OR CREMATORIAL Trinity Memorial			23d. LOCATION Gardens, Waldorf, Maryland					
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., La Plata, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUN 26 1985		25b. REGISTRAR'S SIGNATURE <u>John Davidson - Rendell</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use on the burial/transit permit. Then please remove carbon paper, page 1 and 2, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of other death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be returned to the funeral director. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked by Item 18 shows any injury, or other traumatic event, the medical examiner will be called in.

Items 6, 13a, 13b, 13c, 13e,  
FOR 14, 15, film#G605-  
1 - STATE REGISTRAR 7-10-851bSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 17254

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
CHARLES TALMADGE HEULETT						JUNE		22	85	11A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 23 MRS.	
MALE		WHITE		MON. NOV. 4, 1916		69		68		YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		CHARLES COUNTY	
FLORIDA		U.S.A.								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. ADDRESS		14. DATE OF DEATH	
WALDORF		46 MORAN DRIVE, WALDORF, MD.		SELF EMPLOYED TALLY-HO BBQ		restaurant		46 Moran Drive, 20601		JUN 26 1985	
13a. PRE-ADMISSION RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION)		13b. GIVE RESIDENCE BEFORE ADMISSION		13c. INSIDE CITY LIMITS?		13d. ADDRESS		13e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Florida		Clayton Keystone Hospital		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 1, Box 551		32656			
Maryland		Charles									
14. FATHER'S NAME		Heulett		15. MOTHER'S MAIDEN NAME		Heulett		16. ADDRESS		17. INFORMANT	
FIRST CHARLES		MIDDLE ROSS		LAST HEULETT		FIRST ELIZABETH		ANNE		ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		N/A		262-16-5002		ACUTE RESPIRATORY FAILURE					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF LUNGS, META		DUE TO, OR AS A CONSEQUENCE OF (c) STATIC					
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY?		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED					
Keishan M. Mathur MD						6/22/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		17 MARSHALL HALL							
KRISHAN MATHUR		WALDORF MD. 20601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE JUNE 23/85		23c. NAME OF CEMETERY OR CREMATORIAL Huntt Crematory		23d. LOCATION Waldorf		CITY OR TOWN Charles		COUNTY Md.	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Md. 20601		ADDRESS P.O. Box 156		25a. DATE REC'D. BY REGISTRAR JUN 26 1985		25b. REGISTRAR'S SIGNATURE Keishan M. Mathur					

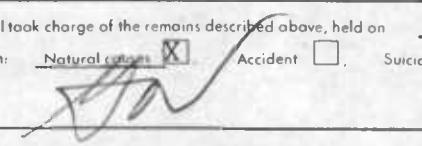
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17255  
REG. NO.

1-  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR M	
Robert			Kennedy	Johnson		6/ 18/ 19	85		8:00		
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 1-18-1961	6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 6/ 18/ 19	MONTH	DAY	YEAR P M	2d. HOUR M	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County					
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS Physician's Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER					12b. KIND OF BUSINESS OR INDUSTRY POWER CO.
13a. STATE MD.	13b. COUNTY CHARLES	13c. CITY OR TOWN LA PLATA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 20646 225 Hawthorne Drive						
14. FATHER'S NAME JOSEPH		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME BERTHA		ELIZABETH		JOHNSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-84-8627		17. INFORMANT BERTHA E. JOHNSON		ADDRESS 411 Nanjemoy Dr. La Plata, Md. 20646					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure Disorder DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE 											M.D. Assistant MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.		TITLE (SPECIFY) ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-22-85		23c. NAME OF CEMETERY OR CEMINATORY SACRED HEART CH. CEM		23d. LOCATION CITY OR TOWN LA PLATA		COUNTY CHARLES			STATE MARYLAND
24. FUNERAL DIRECTOR NAME AREHART FUNERAL HOME, INC.		ADDRESS LA PLATA, MD.		25a. DATE REC'D. BY REGISTRAR JUN 26 1985		25b. REGISTRAR'S SIGNATURE 					

1823 31

182017

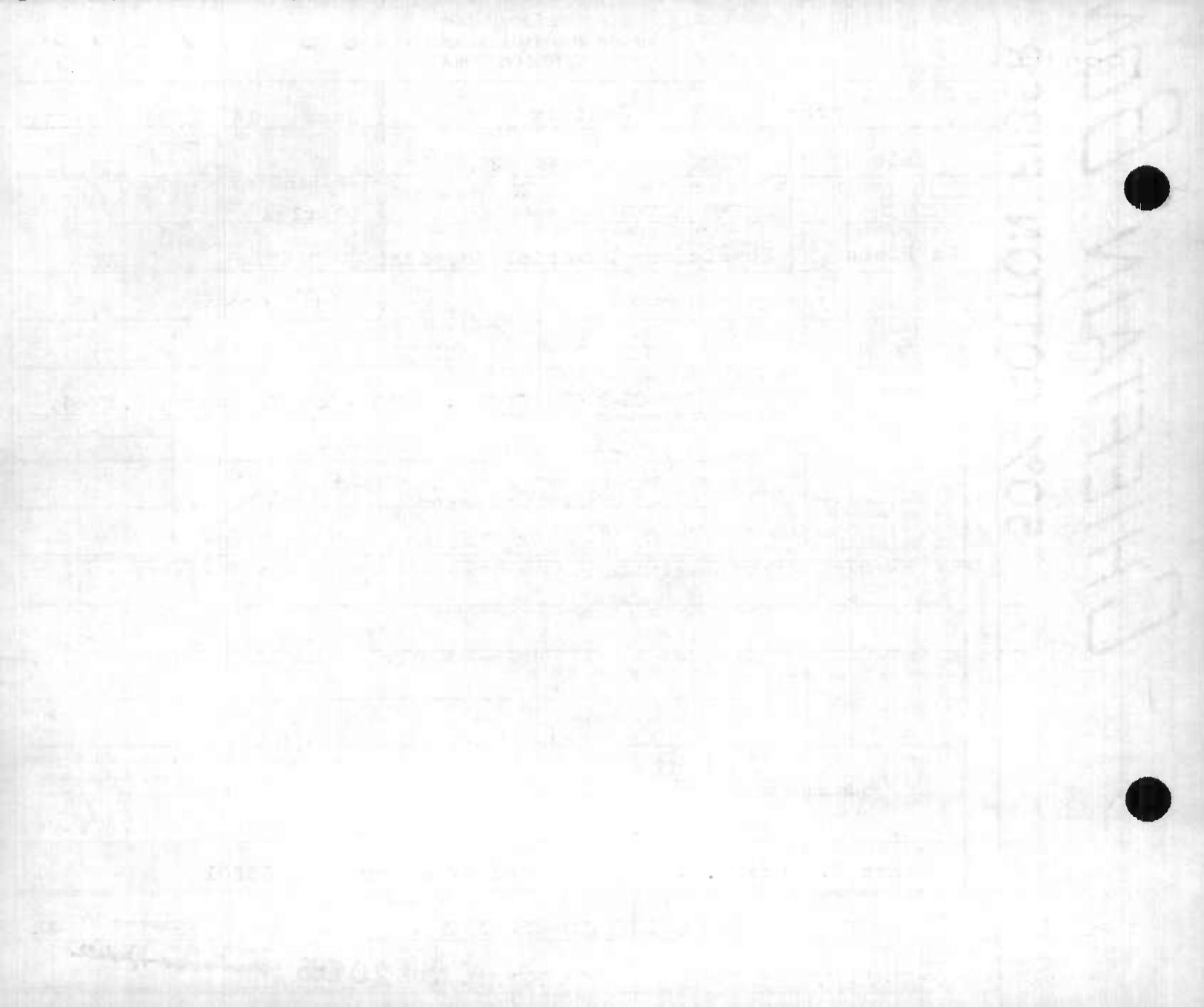
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon paper. Page 4 is to be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, this medical certificate

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	5	1	7	2	5	6											
												REG. NO.																	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR								
			Harry Edward Jupiter												June 16 1985						3:55 AM								
3. SEX			4. RACE			5. DATE OF BIRTH									6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS									
Male			BLACK			MONTH DAY YEAR			MAY 20, 1927						58			MONTHS		DAYS		HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH														
MARYLAND			UNITED STATES												Charles			MD.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY																	
La Plata			Physicians Memorial Hospital									CONSTRUCTION			PRIVATE														
13a. STATE MARYLAND												13b. COUNTY CHARLES			13c. CITY OR TOWN NEWBURG			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE BOX 112 / 20664								
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST														
ARTHUR						JUPITER			LUCILLE						CHAPMAN														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. ADDRESS																				
NO			N/A			214-26-3948			Judy M. Hicks - Box 3L Newburg, Md. 20664																				
19. CAUSE OF DEATH (Enter only one cause per line for Part 1 and Part 2) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												20. APPROXIMATE TIME (IN HOURS) BETWEEN ONSET AND DEATH																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
DUE TO, OR AS A CONSEQUENCE OF (b)																													
DUE TO, OR AS A CONSEQUENCE OF (c)																													
DUE TO, OR AS A CONSEQUENCE OF (d)																													
Respiratory failure																													
Congestive heart failure																													
Central vascular accident																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE														
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 5/15/85 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) had (had) no knowledge of the body after death.						5/24/85			19_____, to 6/15/85 19_____,																				
22b. SIGNATURE Robert T. Pace, M.D.						DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/16/85																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Waldorf, Maryland 20601																										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 19 JUNE 20, 85			23c. NAME OF CEMETERY OR CEMETORY SHILOH CHURCH CFM.			23d. LOCATION CITY OR TOWN NEWBURG			23e. COUNTY CHARLES			STATE MD.														
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUN 20 1985			25b. REGISTRAR'S SIGNATURE John Anderson																				
THORNTON'S FUNERAL HOME																													



177068

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 17257

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Robert					Laabs	June 14, 1985				4:41 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		02/17/1945		40		MONTHS	YEARS	HOURS	MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Charles			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder		12b KIND OF BUSINESS OR INDUSTRY Auto					
13a STATE Md.		13b COUNTY Charles	13c CITY OR TOWN LaPlata	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE General Delivery 20646					
14 FATHER'S NAME Robert		MIDDLE Frederick	LAST Laabs	15. MOTHER'S MAIDEN NAME Bernice							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 151-34-3374		17 INFORMANT Mr. Robert Laabs		ADDRESS Haskell, New Jersey					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Cardiopulmonary arrest		DUE TO, OR AS A CONSEQUENCE OF (b) Hepatorenal failure		APPROXIMATE INTERVAL BETWEEN CHEST PAIN AND DEATH 6 min					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any		DUE TO, OR AS A CONSEQUENCE OF (c) Advanced Hepatocellular disease		5 yrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Mucous ascites, sepsis - E. coli (peritoneal fluid)											
19a DATE OF OPERATION none		19b CONDITION FOR WHICH OPERATION WAS PERFORMED n/a		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED n/a		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, ARM, ETC.) n/a		21f LOCATION STREET n/a		CITY OR TOWN	COUNTY	STATE			
22a I certify that (I) (this hospital) attended the deceased from JUNE 9, 1985 to JUNE 14, 1985, that (I) (we) last saw the deceased alive on JUNE 13, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Paul Pritchett, M.D.		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 6/14/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Pritchett, M.D.		22e ADDRESS La PLata, Maryland 20646									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 6/16/85		23c. NAME OF CEMETERY OR CREMATORIAL STATION		23d. LOCATION CITY OR TOWN La Plata, Maryland					
24 FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a DATE REC'D. BY REGISTRAR JUN 21 1985		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be sent and within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be signed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, Item 22 should be signed by the physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial certificate. Then please remove carbon paper. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner

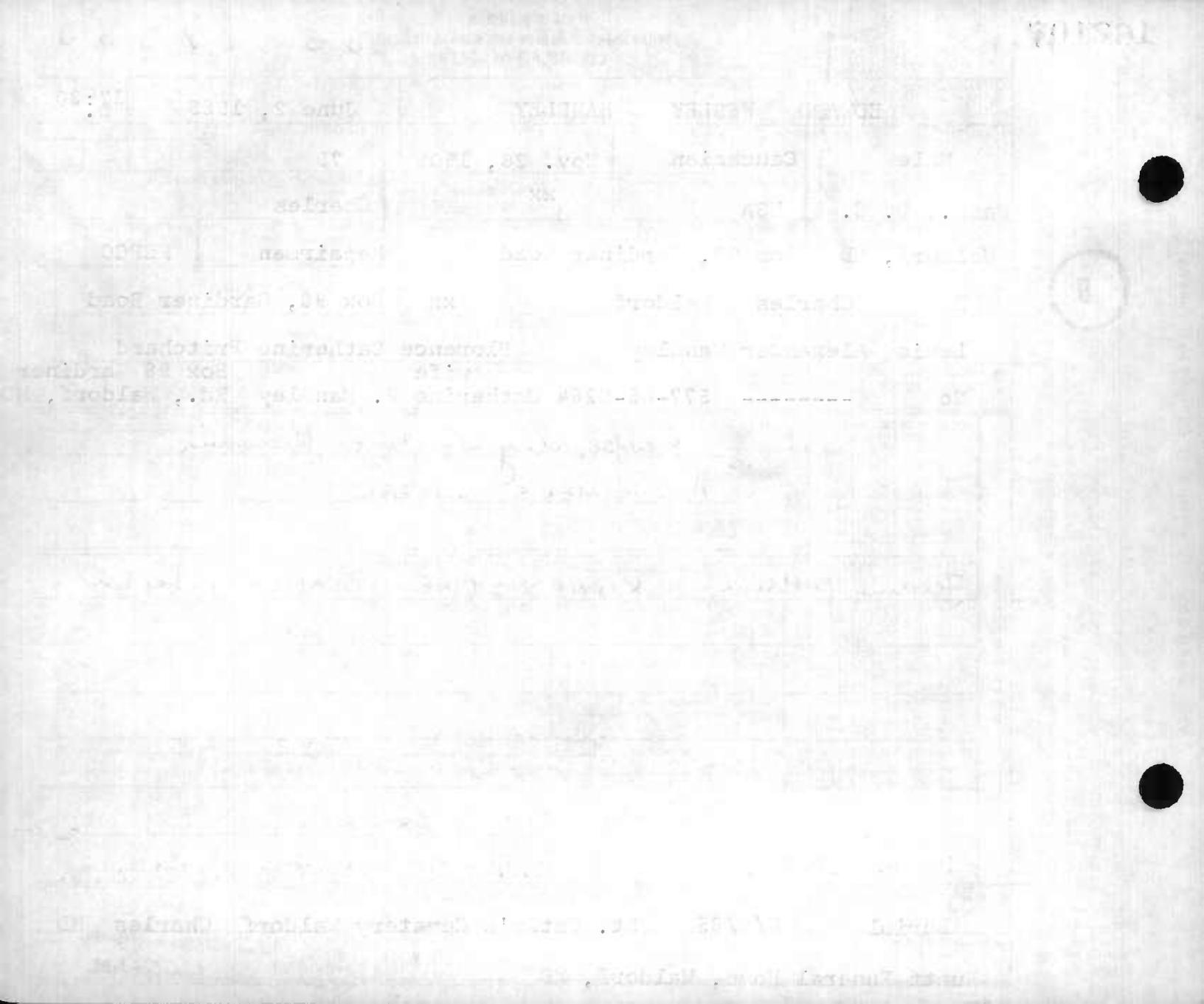
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 7 2 5 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
EDWARD WESLEY MANDLEY						June 2, 1985				12:30			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
Male		Caucasian		MONTH	DAY	YEAR	75						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Wash., D. C.		USA					Charles						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Waldorf, MD		Box 98, Gardiner Road		Repairman			PEPCO						
13a. STATE MD		13b. CITY OR TOWN Charles		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Box 98, Gardiner Road						
14. FATHER'S NAME FIRST Lewis		MIDDLE Alexander		LAST Mandley			15. MOTHER'S MAIDEN NAME FIRST Florence			MIDDLE Catherine			LAST Pritchard
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Wife			ADDRESS Box 98 Gardiner						
No		577-05-0284		Catherine V. Mandley			Rd., Waldorf, MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure, pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ALZHEIMER'S DISEASE</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Feeding problem. KIDNEY STONE - BLADDER infection.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>April 26, 1985</u> to <u>May 2, 1985</u> , that (I) (we) last saw the deceased alive on <u>May 2, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Niren N. Bhaduri</u>		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 2-0601					
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS			P.O. Box 1437 Post Office Rd. Waldorf, Md.								
Niren N. Bhaduri, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE			
Burial		6/6/85		St. Peter's Cemetery			Waldorf		Charles	MD			
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Hunt Funeral Home, Waldorf, MD					JUN 6 1985			d. Raudson-Randall					



178042

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 should be held within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8517259			
REG. NO.															
DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
DOUGLAS WOOD							McCAULEY		June 20, 1985				12:53 p.m.		
1. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. DATE REC'D. BY REGISTRAR		2b. DATE OF DEATH		REG. NO.			
Male		Caucasian		Month Day Year		52		JUN 25 1985		June 20, 1985		8517259			
7a BIRTHPLACE (COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Wash., D. C.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Charles County		La Plata		Physicians Memorial Hospital		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
MD		Charles		Waldorf		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 228-M McDaniel Rd 20601		Wilbur Wood McCauley		Margaret Lee Goldsbey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c) _____ Respiratory Failure		19. DATE OF OPERATION		20. CONDITION FOR WHICH OPERATION WAS PERFORMED		21a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c) _____ Respiratory Failure		21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c) _____ Respiratory Failure		21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) saw the deceased alive on 6-19-1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22a. SIGNATURE Chinmoy Banerjee, M. D.		22b. DEGREE		22c. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED JUN 25 1985			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Md. Vet. Cemetery		23d. LOCATION Cheltenham		24. FUNERAL DIRECTOR NAME			
Chinmoy Banerjee, M. D.		Charles Professional Bldg. #200 Waldorf, MD 20601		Burial		6/24/85		Pr. Geo.		STATE MD		ADDRESS Huntt Funeral Home, Waldorf, MD			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		JUN 25 1985		JUN 25 1985		REG. NO.		Huntt Funeral Home, Waldorf, MD			

SEARCHED  
INDEXED  
SERIALIZED  
FILED



170124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the general director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	5	1	7	2	6	0
1 - FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
Edwin Harrison Mountcastle, Jr.								June 8, 1985					3:20A M			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
male		white		MONTH September		DAY 11		YEAR 1915		69		YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.						
Virginia		USA						Charles								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY										
La Plata		Physicians Memorial Hospital		Plumber		Plumbing										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE								
MD		Charles		Waldorf		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		534 Garner Avenue 20601								
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME								
Edwin Harrison Mountcastle, Sr.								Ida								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		daughter		ADDRESS								
Yes WW II		579-01-6928		Carolyn Brown				6511 Hallam Dr. Upper Marlboro, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		Cardiac arrest.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Severe obstructive lung disease.												
		(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 6-7-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				April 19 82		to 6-8-1985										
22b. SIGNATURE		22c. DEGREE		M.D.		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22d. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS														
Girija Rath, M.D.		La Plata, Maryland														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE						
Burial		6/11/85		Md. Veterans Cem.		Cheltenham		Pr. Geo.		MD						
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
Huntt Funeral Home, Waldorf, MD				JUN 12 1985		Girija Rath										

AS1031



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17261  
REG. NO.

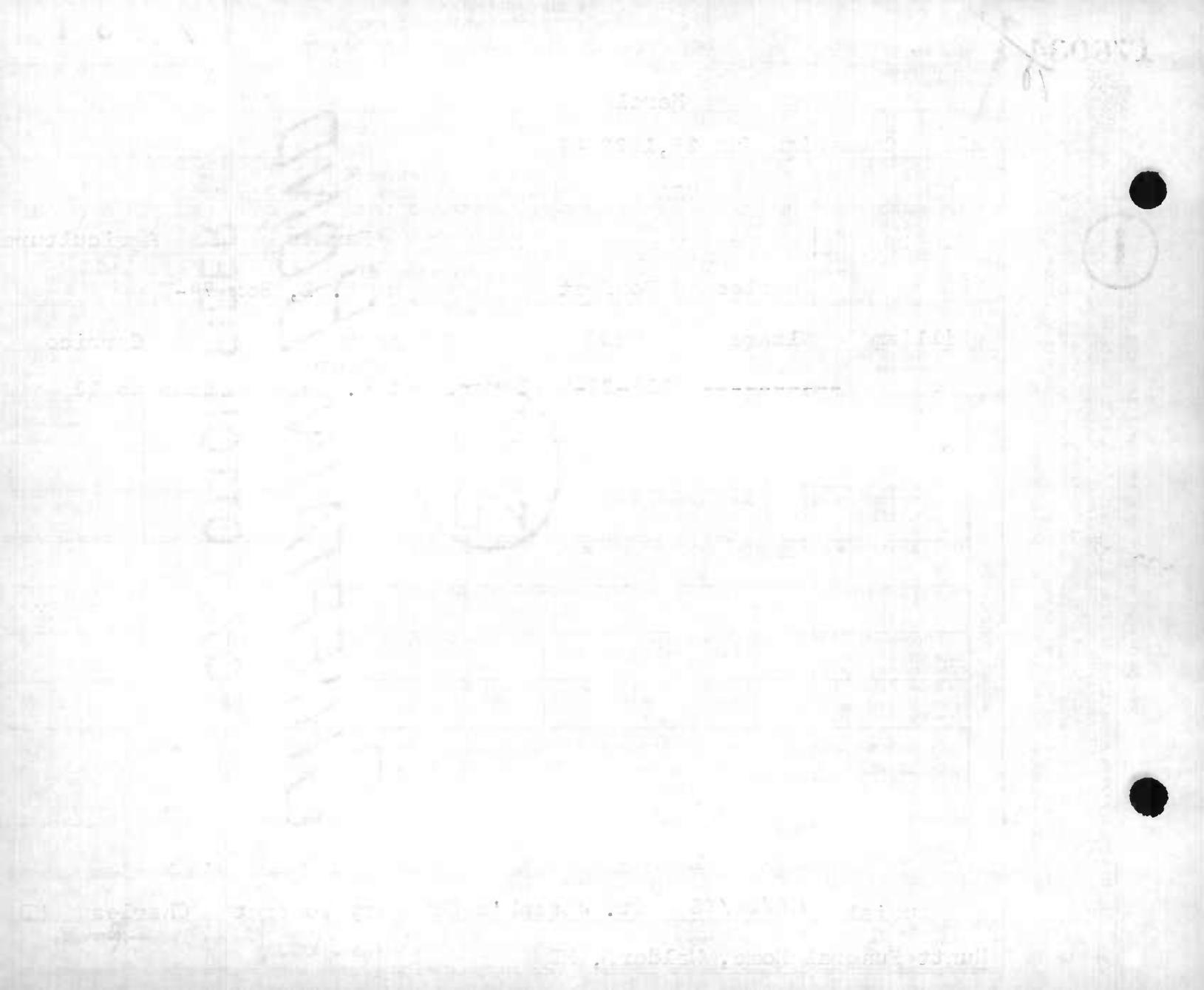
176034

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. FORWARD TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 4 AND PAGE 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST Patrick	MIDDLE Harold	LAST Mudd	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	MONTH 6	DAY 16	YEAR 1985	2b. HOUR M
3. SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR Jun 28, 1938	6. AGE (IN YEARS LAST BIRTHDAY) 46 RS.	7. IF UNDER 1 YR. MONTHS 0	8. IF UNDER 24 HRS. HOURS 0	9. MIN 0	2c. DATE PRONOUNCED DEAD 6 16 1985	2d. HOUR a	2d HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County,		MD		
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture		
13a. STATE MD	13b. COUNTY Charles	13c. CITY OR TOWN Pomfret	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET ADDRESS Rt. 2, Box 74-T					20675	
14. FATHER'S NAME FIRST William			MIDDLE Elzare	LAST Mudd	15. MOTHER'S MAIDEN NAME FIRST Margaret		MIDDLE	LAST Carrico		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-38-4692		17. INFORMANT mother	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY? BODY ONLY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
22b. TITLE (SPECIFY) M.D. <u>Assistant</u> MEDICAL EXAMINER										
EXAMINER'S NAME (TYPE OR PRINT) <u>Ann M. Dixon, M.D.</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/20/85		23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's Cemetery		23d. LOCATION CITY OR TOWN Pomfret		COUNTY Charles	STATE MD	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, MD		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUN 20 1985		25b. REGISTRATION NO.				



171050

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17262  
REG. NO.

REG. NO.

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 4 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS 201 W PRESTON ST BALTIMORE MD 21201

1. DECEASED NAME (TYPE OR PRINT)			William Proctor			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. MONTH DAY YEAR			2b. HOUR M		
3. SEX <b>M</b>	4. RACE <b>B</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 1 59</b>	6. AGE (IN YEARS (LAST BIRTHDAY) <b>26</b> YRS.	7. IF UNDER 1 YR. MONTHS <b>0</b>	8. IF UNDER 24 HRS. MONTHS <b>0</b>	9. DATE PRONOUNCED DEAD	10. MONTH <b>6</b>	11. DAY <b>8</b>	12. YEAR <b>1985</b>	13. HOUR <b>10 AM</b>	14. MINUTE <b>00</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles County</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		
10. CITY OR TOWN OF DEATH <b>LaPlata</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>N/A</b>			12a. USUAL OCCUPATION (TYPE OF WORK) <b>Laborer</b>			12b. STREET ADDRESS <b>Box 288</b>			12c. ADDRESS <b>357C Whiteland</b>		
13a. STATE <b>Md.</b>			13b. CITY OR TOWN <b>Prince Geos. Brandywine</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>Box 288</b>			20613		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas C. Proctor</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Proctor</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219 74 8207</b>			17. INFORMANT <b>Thomas Proctor:ing Rd., Brandywine</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8147</b>			IMMEDIATE CAUSE (a) <b>craniocerebral trauma</b>			DUE TO, OR AS A CONSEQUENCE OF (b) <b></b>			DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>in seconds</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b></b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10:00 P.M. 8 June 85</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>struck pedestrian</b>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Street</b>			21f. LOCATION STREET <b>At 227</b>			CITY OR TOWN <b>Brym Road</b>			COUNTY <b>Charles</b>		
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>			and in my opinion								
ACTUAL SIGNATURE <b>H. M. Maher</b>			TITLE (SPECIFY) <b>M.D.</b>			MEDICAL EXAMINER <b>Charles Co.</b>			DATE SIGNED <b>8 June 85</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>H. M. Maher - Haf (no</b>			ADDRESS <b>SE# Box 1020 LaPlata Md 20686</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>14 June '85</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Peter's Ch Cem</b>			23d. LOCATION CITY OR TOWN <b>Waldorf, Chas., Md.</b>			COUNTY <b>Charles</b>		
24. FUNERAL DIRECTOR NAME <b>Marstell Adams Aquasco Md 20608</b>			ADDRESS <b></b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 17 1985</b>			25b. REGISTRAR'S SIGNATURE <b>Julie Dawson-Rendell</b>					

02013.4

189060

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 7 2 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
Roy Ogle Reed						6-25-85				6:45 A M					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
MALE		WHITE		1896 February 27		89		MONTHS	YEARS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.							
NEW MEXICO		U.S.A.				CHARLES									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
LaPlata		Physicians Memorial Hospital				Farmer		Own Farm							
13a. STATE Md.		13b. COUNTY Charles	13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Chas. Co. Nursing Home 20646								
14. FATHER'S NAME FIRST		MIDDLE	LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST							
Wendell			Reed		Margaret			Ogle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Yes		WWI		213-12-4151		Mary Waigand		501 New York Avenue Takoma Park, Md. 20912							
III. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Pulmonary Disease</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Blueness</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>6-24</u> 19 <u>85</u> , and that <u>(I)</u> (we) last saw the deceased alive on <u>6-24</u> 19 <u>85</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (we) did not view the body after death.															
22b. SIGNATURE <u>Henry L. Burke</u>		DEGREE				ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Henry L. Burke</u>		22e. ADDRESS <u>Howard Street, LaPlata, Md. 20646</u>				22f. DATE SIGNED <u>6-25-85</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-28-85		23c. NAME OF CEMETERY OR CREMATORIAL Trinity Mem. Gardens		23d. LOCATION CITY OR TOWN Waldorf		COUNTY Charles		STATE Maryland					
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc.		ADDRESS La Plata, Md.				25a. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE <u>JUL 01 1985 Julie Dawson-Randall</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be  
reversed by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3  
should be detached for use as the burial permit. Then please remove carbon papers from the original and  
send the original to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.IMPORTANT: If item 21 is marked or item 16 is checked, any injury, or other traumatic event, the medical examiner  
will be notified.

101

184097

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 7 2 6 4

REG. NO.

1-  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
HERMAN N.M.N. RICE						June	21, 1985			5:20 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male		White		July 6, 1898		86			MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Kentucky		U.S.A.				Charles County, MD.			MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR (TYPE OF WORK OR MOST OF WORKING LIFE)		
La Plata		Meridan Nursing Center				Retired			Industry		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
Maryland		Charles		Pomfret		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Route #2, Box 243, 20675		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE LAST			
Thomas			Rice		Ann			Marshall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
No		A-718-16-2955		Joan R. Dyer			Daughter, Same as #13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneum Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Fibrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/19</u> to <u>6/22</u> , 19 <u>85</u> , to <u>Jun</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>6/19</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22c. DATE SIGNED <u>6/22/85</u>
22b. SIGNATURE <u>Michael Leatherwood</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael Leatherwood</u>		22e. ADDRESS <u>Waldorf Medical Park, 1 RT 341, Waldorf, MD 20601</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 6/25/85		23c. NAME OF CEMETERY OR CREMATORIAL Mount Calvary Cem.		23d. LOCATION CITY OR TOWN Ashland, Kentucky			STATE		
24. FUNERAL DIRECTOR NAME Arenhart Funeral Home, Inc., La Plata, Md.		ADDRESS Lazear Funeral Home, Ashland, Kentucky		25a. DATE REC'D. BY REGISTRAR JUN 27 1985			25b. REGISTRAR'S SIGNATURE <u>Indicates Death</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner



6  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17265  
REG. NO.

1711263

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE  
EST. DEATH  
MATED

KNOWN  
XX

MONTH DAY YEAR

2b. HOUR

3. SEX  
Male

4. RACE  
Cau.

5. DATE OF BIRTH  
MONTH DAY YEAR

6. AGE (IN YEARS  
LAST BIRTHDAY)

7. IF UNDER 1 YR.  
MONTHS DAYS HOURS MIN.

2c. DATE  
PRONOUNCED  
DEAD

MONTH DAY YEAR

2d. HOUR

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)  
MD

10. CITY OR TOWN OF DEATH  
La Plata

11. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE  
Maryland

13b. COUNTY  
Charles

13c. CITY OR TOWN  
Newburg

7b. CITIZEN OF WHAT COUNTRY?  
USA

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Physician's Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)  
Laborer

12b. KIND OF BUSINESS  
OR INDUSTRY  
Farm

14. FATHER'S NAME  
FIRST  
William Edward Rison

MIDDLE  
LAST

15. MOTHER'S MAIDEN NAME  
FIRST  
Mattie

MIDDLE  
Elizabeth

LAST  
Bowie

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)  
NO

16b. SOCIAL SECURITY NO.  
218-28-4038

17. INFORMANT  
sister

ADDRESS  
2000 Hunting-  
ton Ave. Alex., VA

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES  NO

21a. EXTERNAL CAUSE WAS

UNDERLYING  OR  
CONTRIBUTING  CAUSE OF DEATH

21d. INJURY OCCURRED

WHILE  NOT WHILE   
AT WORK  AT WORK

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR

P.M. 19

21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on

death resulted from

Natural cause

Accident

Suicide

Homicide

Undetermined manner

23a. EXAMINER'S NAME  
(TYPE OR PRINT)

23b. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23c. DATE

6/17/85

23d. NAME OF CEMETERY OR CREMATORIAL

St. Ignatius Cemetery

Hilltop

Charles

MD

23e. LOCATION  
CITY OR TOWN

23f. COUNTY

STATE

24. FUNERAL DIRECTOR  
NAME

Huntt Funeral Home, Waldorf, MD

ADDRESS

JUN 18 1985

25a. DATE REC'D. BY REGISTRAR

JUN 18 1985

25b. REGISTRAR'S SIGNATURE

John Huntt

MD

1000 MOTORS



183095

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17266

REG. NO.

1-  
FOR  
STATE  
REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B (GIV PAGE 3) AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 5. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1-2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN <input type="checkbox"/> OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
Sheila			Ann	Rogers	XX	6-21	19	85	M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Female	Cauc.	9-13-1949	35 yrs.			6-22	19	85	3:15 p.m.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Norfolk, Va.		U.S.A.				Charles County, Nurse					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE				12b. KIND OF BUSINESS OR INDUSTRY	
Bel Alton		Bel Alton Motel, Room 23				Registered				Hospital	
13. STATE	14. PRINCIPAL CITY OR TOWN	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS							
Md.	Prince Georges	Temple Hills	YES <input checked="" type="checkbox"/>	5002 Branch Avenue 20748							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. SOCIAL SECURITY NO.		17. INFORMANT		# 13			
William Thomas Campbell		Mary Frances Alligood		225-70-6863		Freda Campbell (sister) Same as					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Chest (unspecified) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 6-21 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot herself							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC) motel room		21f. LOCATION STREET Bel Alton Motel, Bel Alton, Charles Co., Md.		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>		and in my opinion							
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE 6/27/85		23c. NAME OF CEMETERY OR CREMATORIAL Forest Lawn Cemetery		23d. LOCATION CITY OR TOWN Norfolk		COUNTY		STATE Virginia	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUN 27 1985		25b. REGISTRAR'S SIGNATURE Lisa Davidson Pendell					
E. Barnes		Fleming Funeral Service - Benson, Md.									
BP											
DHMH - T7 (VR A15 ME (5))											



164077

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 17261

REG. NO.

FOR  
1 - STATE  
REGISTRAR

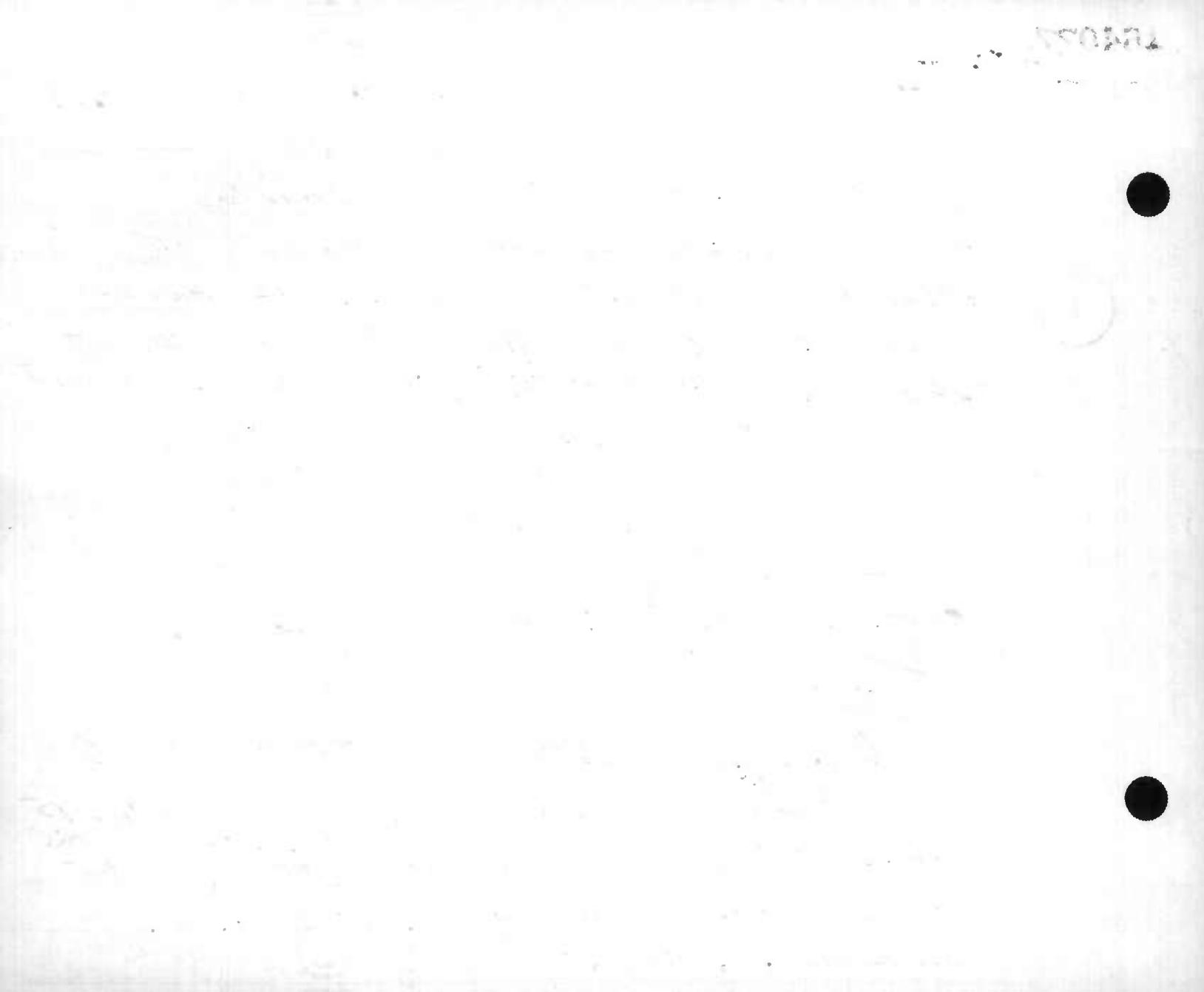
1. DECEASED NAME <u>Irma Estelle Shadie</u>				2a. DATE OF DEATH <u>June 5 1985</u>	MONTH <u>JUN</u>	DAY <u>5</u>	YEAR <u>1985</u>	2b. HOUR <u>3:45 PM</u>				
3. SEX <u>F</u>	4 RACE <u>W</u>	5. DATE OF BIRTH MONTH <u>Oct</u> DAY <u>5</u> YEAR <u>21</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>63</u>				IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>	IF UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <u>Charles</u>						
10. CITY OR TOWN OF DEATH <u>Waldorf</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Box 272 Hwy 228</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>teacher</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>Public school</u>			
13a. STATE <u>MD</u>	13b. COUNTY <u>Charles</u>	13c. CITY OR TOWN <u>Waldorf</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <u>Box 272 Hwy 228</u>					
14. FATHER'S NAME FIRST <u>Eugene</u> MIDDLE <u>Leigh</u> LAST <u>Edelen</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Marguerite</u> MIDDLE <u>—</u> LAST <u>Willett</u>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>				16b. SOCIAL SECURITY NO. <u>215-18-0248</u>	17. INFORMANT <u>Eugene D. Shadie</u>	ADDRESS <u>Box 272 Hwy 228 - Waldorf</u>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Renal Cell Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____												
19a. DATE OF OPERATION <u>Sept 1 1984</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Renal cell Cancer</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <u>A.M.</u> MONTH <u>JUN</u> DAY <u>5</u> YEAR <u>85</u> P.M. <u>—</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>—</u>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>—</u>		21f. LOCATION STREET <u>—</u> CITY OR TOWN <u>—</u> COUNTY <u>—</u> STATE <u>—</u>								
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>83</u> to <u>June</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>June</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Rene Grace</u>		DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>June 85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Rene Grace MD</u>		22e. ADDRESS <u>9131 Piscataway Rd Clinton, MD, 20735</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6/8/85</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Resurrection Cm.</u>		23d. LOCATION CITY OR TOWN <u>Clinton</u>		23e. COUNTY <u>Prince George</u>		23f. STATE <u>MD</u>		
24. FUNERAL DIRECTOR <u>Huntt Funeral Home, Waldorf, MD</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 10 1995</u>				25b. REGISTRAR'S SIGNATURE <u>J. Henderson</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

DHMH-16 20M (VRA 15, 4) 7/78



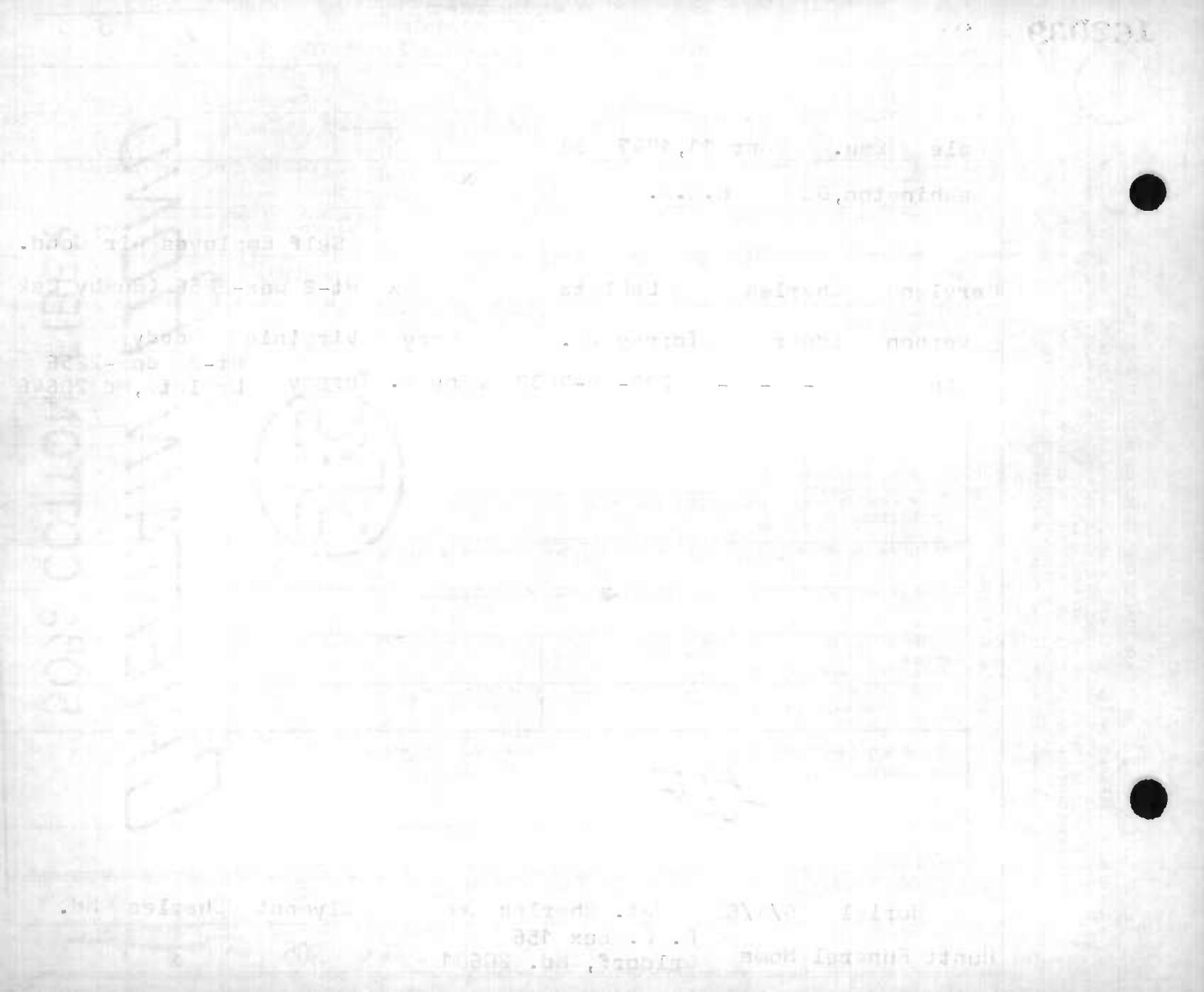
162039

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17268

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE KNOWN MONTH DAY YEAR												2b. HOUR								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			<input checked="" type="checkbox"/> DEATH MATED		6/ 1/ 1985		M							
Gregory			Allen			Torney			IF UNDER 1 YR.		IF UNDER 24 HRS.												
1. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			MONTHS		DAYS		HOURS		MIN					
Male			Cau.			Apr 11, 1947			38 RS.														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			2c. DATE PRONOUNCED DEAD											
Washington, DC			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Charles County, MD.			6/ 1/ 1985 A M											
III. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
LaPlata			Physician's Memorial Hospital												Self Employed			Air Cond.					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			14. ADDRESS								
Maryland			Charles			LaPlata						Rt-2 Box-2256 (Bumby Oak											
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST											
Vernon			Edgar			Torney Jr.			Mary			Virginia			Moody								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
No			- - -			217-46-7838			Judy A. Torney			Rt-2 Box-2256 LaPlata, Md 20646											
IMMEDIATE CAUSE (a)			Hanging																				
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last.																							
(b)			DUE TO, OR AS A CONSEQUENCE OF																				
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
5:00 AM 6/1/ 1985						subject hanged self while incarcerated																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
			jail cell			Waldorf St. Pol. Barracks, Charles Co., Md.																	
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																				
ACTUAL SIGNATURE			TITLE (SPECIFY)																				
EXAMINER'S NAME (TYPE OR PRINT)			Gregory R. Kauffman, M.D.			ADDRESS			M.D. Assistant MEDICAL EXAMINER														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY			STATE								
Burial			6/4/85			St. Charles Cem			Glymont			Charles			Md.								
24. FUNERAL DIRECTOR NAME			ADDRESS			P. O. Box 156			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Huntt Funeral Home			Waldorf, Md. 20601			JUN 4 1985						John Davidson -											



189048

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (PAGE 1, LINE 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 17269			
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI. DEATH MATED			2b. HOUR			
			HERBERT M. WATERFIELD						<input checked="" type="checkbox"/> 6-24-85 19						
2. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		
Male		Caucasian	4/2/09			76 yrs.							6-24-85 19		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Charles County						
VA			USA												
10. CITY OR TOWN OF DEATH LaPlata			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Timber buyer			12b. KIND OF BUSINESS OR INDUSTRY Timber						
13. STATE MD			13b. COUNTY Charles			13c. CITY OR TOWN Cobb Island			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS General Delivery				
14. FATHER'S NAME Otis			MIDDLE LAST			15. MOTHER'S MAIDEN NAME Evelyn									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. No xxxxxxxxxxxx 223-14-6327			17. INFORMANT H. Marshall Waterfield, Waldorf, MD			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? (CHEST ONLY) XX									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described below. The death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT)			Margarita A. Korell, M.D.			ADDRESS 111 PENN STREET			DATE SIGNED 6-26-85						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 6/27/85			23c. NAME OF CEMETERY OR CREMATORIAL Historyland Mem. Pk. King George, King Geo., VA			23d. LOCATION CITY OR TOWN COUNTY STATE						
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, MD			25a. DATE REC'D. BY REGISTRAR JUL 01 1985			25b. REGISTRAR'S SIGNATURE <i>John Huntt</i>									

CHOCOLATE

A

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH EVIDENCE. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

ITEMS 18-22a 8/8/85 mth F606 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH						17270
						REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			LAST	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH DAY YEAR	2b. HOUR
THOMAS ASBURY WELCH				<input checked="" type="checkbox"/> 6-24-85 19		
3. SEX MALE	4. RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR 7/3/35	6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH Charles County	2d. HOUR 6-24-85 19	7d. HOUR 7:36P M	
10. CITY OR TOWN OF DEATH LaPlata	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic	12b. KIND OF BUSINESS OR INDUSTRY Self-emp.			
13a. STATE MD	13b. COUNTY Charles	13c. CITY OR TOWN Waldorf	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 37 Acton Lane	13e. STREET ADDRESS 37 Acton Lane	20601	
14. FATHER'S NAME FIRST James	MIDDLE R.	LAST Welch	15. MOTHER'S MAIDEN NAME FIRST Veva	MIDDLE	LAST Sammons	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b. SOCIAL SECURITY NO. -----	17. INFORMANT Not available	Betty Ann Welch	SAME AS 13A	ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution						
Conditions, if any, which gave rise to immediate cause (a) starting the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR AM-MONTH DAY YEAR 6:44P.M. 6/24/85	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject came in contact with a wire cage of an energized electrical cord				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) in garage	21f. LOCATION STREET 37 Acton La. Waldorf, Maryland	CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <u>Margarita A. Korell</u> M.D. Assistant MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 6/27/85	23c. NAME OF CEMETERY OR CREMATORIAL Huntt Crematory	23d. LOCATION CITY OR TOWN Waldorf	COUNTY Charles	STATE MD	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, MD	ADDRESS	25a. DATE REC'D. BY REGISTRAR 01/10/85	25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall			
D7/84 BP 01217 DHMH - 17 (VR A15 ME (5))						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						851727			
REG. NO.						11:45AM			
DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR	
PHILIP	DONALD		WILSON	June 15, 1985				11:45AM	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Male	Caucasian	MONTH	DAY	YEAR	64	YRS	MONTHS	DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia	U.S.A.	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Charles			MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Waldorf	Hwy 382 Box 123C					Salesman			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE	
Maryland	Charles	Waldorf			YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>		Hwy 382 Box 123C 20601	
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16b. SOCIAL SECURITY NO.		
Philip	Edwin	Wilson		Margaret M. Wike			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
Yes		1944-1944		17. INFORMANT			16b. SOCIAL SECURITY NO.		
		213-16-4246		Nancy H. Wilson			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH: Enter only one cause per line for item 18, and item 19. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Malignant glioma</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
	P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1984</i> to <i>1985</i> , that (I) (we) last saw the deceased alive on <i>6/18/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <i>R. Pace</i> DEGREE									
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22c. DATE SIGNED <i>6/16/85</i>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. Pace</i>				22e. ADDRESS Waldorf, Maryland 20601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL TRINITY MEM. GARDENS			23d. LOCATION Waldorf	23e. COUNTY Charles	23f. STATE Md.	
Burial		6/18/85							
24. FUNERAL DIRECTOR NAME <i>Huntt Funeral Home</i> ADDRESS <i>Waldorf, Md 20601</i> 25a. DATE REC'D. BY REGISTRAR <i>JUN 18 1985</i> 25b. REGISTRAR'S SIGNATURE <i>John Huntt</i>									

